Kindergarten Registration Guide

New Families

In order for your child to be fully registered, you must complete the following:

1. Online registration (**OLR**)
2. Fill out forms
3. Provide Documentation

Instructions for families new to School District U-46

Step 1: Online Registration

Please go to our website www.u-46.org/registration and follow the instructions for New Families.

You will fill out one application on the New Family Kiosk for all of your students, making sure to answer all of the questions in each section before selecting "next" to move on to the next section.

Important! Write down your OLR application number _____

Make sure you select the Submit button at the end of the registration, and then contact your school.

> **NOTE:** Stepparents or grandparents are not considered guardians, they should be listed as emergency contacts. Parents/Guardians should not be listed as Emergency Contacts.

Step 2: Contact School

Please contact your school to provide them with the following forms and documentation. You can find all the requirements and forms on our website at www.u-46.org/registration, then go to Additional Forms & General Information.

a. Student's Birth Certificate
b. Proof of Custody and Residency and the Category A & B documents as listed on the form
c. Health Requirements and Pre-Admission Health Form

Contact your school or registration office if you need assistance completing the online registration or with turning in documentation.

For more information visit www.u-46.org/registration or call 847-888-5000

Early Learners ext. 6991
Registration Office ext. 5016

Please see the Registration Guide for Current Families if you have children already attending school in U-46

If you reside with another family, you must fill out and notarized the Affidavit of Resident Residency of Others. Affidavits are also renewed every school year.

Si usted vive con un familiar o con otra persona, deberá completer y notarizar la carta Declaración Jurada de Residente Respecto a Residencia de Otros. Las Declaraciones Jurades también se renuevan cada ciclo escolar.

Guía de Inscripción de Kindergarten

Familias Nuevas

Para que su hijo(a) esté completamente inscrito(a), debe completar lo siguiente:

1. Inscripción en línea
2. Completar formularios
3. Entregar documentación

Instrucciones para las nuevas familias del Distrito Escolar U-46

Paso 1: Inscripción en línea

Visite nuestro sitio web www.u-46.org/registration y siga las instrucciones para Familias Nuevas.

Deberá completar una solicitud en el quiosco para familias nuevas para todos sus estudiantes, asegurándose de responder a todas las preguntas de cada sección antes de seleccionar "siguiente" para pasar a la siguiente sección.

¡Importante! Anote su número de solicitud _____

Asegúrese de seleccionar el botón Enviar al final de la inscripción y, una vez hecho esto, comuníquese con su escuela.

NOTA: Los padrastros o abuelos no se consideran tutores legales, deben aparecer en la lista como contactos de emergencia. Los padres/tutores legales no deben aparecer como contactos de emergencia.

Paso 2: Comuníquese con la escuela

Comuníquese con su escuela para entregar los siguientes formularios y documentación. Puede encontrar todos los requisitos y formularios en nuestro sitio web en www.u-46.org/registration, luego vaya a formularios adicionales e información general.

a. Acta de nacimiento del estudiante

b. Prueba de custodia y residencia y los documentos de las categorías A y B que se indican en el formulario

c. Requisitos de salud y Formulario de salud pre-admisión

Comuníquese con su escuela u oficina de inscripción si necesita ayuda para completar la inscripción en línea o para entregar la documentación

Para más información visite www.u-46.org/registration o llame al 847-888-5000
Educación Temprana ext. 6991
Oficina de Registración ext. 5016

Por favor, vea la Guía de Inscripción para Familias Actuales si tiene hijos(as) que ya asisten a la escuela en U-46

If you reside with another family, you must fill out and notarized the Affidavit of Resident Residency of Others. Affidavits are also renewed every school year.

Si usted vive con un familiar o con otra persona, deberá completer y notarizar la carta Declaración Jurada de Residente Respecto a Residencia de Otros. Las Declaraciones Jurades también se renuevan cada ciclo escolar.

Kindergarten Registration Guide

Current Families

In order for your child to be fully registered, you must complete the following:

1. Online registration (**OLR**)
2. Contact your school to provide the required documents and forms

Instructions for families with students currently enrolled in School District U-46

Step 1: Online Registration

Please use this link for your Infinite Campus Parent account.

Use the **Shortcuts** menu or the **More** tab and select **Online Registration**.

Please select the option for **Existing Student Registration,** even though you are registering a new kindergartener or adding a child for a preschool screening. You will be registering ALL of your students at the same time.
Important! Write down your OLR application number _____

NOTE: Step parents or grandparents are not considered guardians, they should be listed as emergency contacts. Parents/Guardians should not be listed as Emergency Contacts.

Step 2: Contact School

Please contact your school to provide them with the following forms and documentation. You can find all the requirements and forms on our website at www.u-46.org/registration, then go to Additional Forms & General Information.

a. Student's Birth Certificate
b. Proof of Custody and Residency and the Category A & B documents as listed on the form
c. Health Requirements and Pre-Admission Health Form

Contact your school or registration office if you need assistance completing the online registration or with turning in documentation.

For more information visit www.u-46.org/registration or call 847-888-5000

Early Learners ext. 6991
Registration Office ext. 5016

Please see the Kindergarten Registration Guide for New Families if you are new to U-46

If you reside with another family, you must fill out and notarized the Affidavit of Resident Residency of Others. Affidavits are also renewed every school year.

Si usted vive con un familiar o con otra persona, deberá completer y notarizar la carta Declaración Jurada de Residente Respecto a Residencia de Otros. Las Declaraciones Jurades también se renuevan cada ciclo escolar.

Guía de Inscripción de Kindergarten

Familias Actuales

Para que su hijo(a) esté completamente inscrito(a), debe completar lo siguiente:

1. Inscripción en línea
2. Comunícarse con su escuela para proporcionar los documentos y formularios necesarios.

Instrucciones para las familias con estudiantes actualmente matriculados en el Distrito Escolar U-46

Paso 1: Inscripción en línea

Por favor use este enlace para ir a su cuenta de padres de Infinite Campus

Utlize el menu de acceso rápido (**Shortcuts)** o la pestaña **Más** y seleccione **Inscripción en Línea.**

Por favor seleccione la opción **Inscripción de Estudiantes Actuales**, aunque esté inscribiendo a un nuevo estudiante de kinder o agregando a un niño(a) para una evaluación preescolar. Usted estará inscribiendo a TODOS sus estudiantes al mismo tiempo.

¡Importante! Anote su número de solicitud _____

NOTA: Los padrastros o abuelos no se consideran tutores legales, deben ser agregados solamente como contactos de emergencia. Los padres/tutores legales no deben aparecer como contactos de emergencia.

Paso 2: Comuníquese con la escuela

Comuníquese con su escuela para entregar los siguientes formularios y documentación. Puede encontrar todos los requisitos y formularios en nuestro sitio web en www.u-46.org/registration, después vaya a formularios adicionales e información general.

a. Acta de nacimiento del estudiante

b. Prueba de custodia y residencia y los documentos de las categorías A y B que se indican en el formulario

c. Requisitos de salud y Formulario de salud pre-admisión

Comuníquese con su escuela u oficina de inscripción si necesita ayuda para completar la inscripción en línea o para entregar la documentación.

Para más información visite www.u-46.org/registration o llame al 847-888-5000

Educación Temprana ext. 6991

Oficina de Registración ext. 5016

Por favor vea la Guía de inscripción para familias nuevas si usted es nuevo en U-46

Kindergarten Registration

If you reside with another family, you must fill out and notarized the Affidavit of Resident Residency of Others. Affidavits are also renewed every school year.

Si usted vive con un familiar o con otra persona, deberá completer y notarizar la carta Declaración Jurada de Residente Respecto a Residencia de Otros. Las Declaraciones Jurades también se renuevan cada ciclo escolar.

Proof of Custody and Residency Form

Illinois law provides that the residence of a student is deemed to be the same as the residence of the person who has legal custody of the student and permits only students who are residents of the School District to enroll and attend on a tuition-free basis. The person claiming custody must also reside in the District. To assist the District in determining residency and legal custody, this form must be completed. The District may investigate the residency of any student before or after enrollment and require the involved persons to provide additional information to be considered by the District in determining residency. Enrollment is not completed, and attendance will usually not be permitted, until all residency issues are resolved.

I. Identification: (Please Print):

Student:

Name

Birth Date

Student School ID #

Person Claiming Custody/Enrolling Student:

Name

Address

Address

Phone

Relationship to Student

Residency of Person with Whom Student Lives and Who Claims Custody of the Student:
As initial proof of residency, **the person with whom the student lives in the District and who claims custody of the student** must attach one item from Category A and one item from Category B, all of which must be acceptable to the District.
If the person enrolling the student claims the student is (1) homeless, or (2) attending school upon a determination of the Department of Children and Family Services, only the appropriate line in Category C must be checked.

*** It is not required to show personal information (account #'s, payment amounts $, etc.) on these forms. Please feel free to block out any of the personal information that does not relate to proof of your residency. All documents must be current and include the address of the student's residence.**

***Category A. Check and attach a copy of at least one of the following documents:**
____ 1. The most recent real estate tax bill for my residence showing me as the tax payer
____ 2. Mortgage Papers/Statement
____ 3. Signed lease for my residence
____ 4. A closing statement for the purchase of my residence
____ 5. Notarized Affidavit of Resident Regarding Residency of Others Form (must provide 2 proofs from Cat. B)
____ 6. Notarized statement claiming month to month lease (must provide 2 proofs from Cat. B)

***Category B. Check and attach a copy of at least one of the following documents:**
____ 1. Current Gas, Electric, or Water Bill (dated within one month of the student registration date)
____ 2. Valid government issued picture ID with current address in which the student resides/State of Illinois address change letter.
____ 3. Public Aid Card/Food Stamp Card/Medical letter (with parent name/student and address)
____ 4. Current homeowners/renters insurance certificate
____ 5. Current Cable Bill/Internet/Dish
____ 6. Vehicle Registration

Category C. None of the documents in categories A or B above are applicable because:
____ 1. The student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act
____ 2. The student is enrolling based on the determination of the Department of Children and Family Services, attach evidence from DCFS
____ 3. Proof of Residency will be established within 30 calendar days; however, a real estate contract, closing statement or lease MUST be presented as initial proof of residence. If the student does not become a resident of the district within 30 days, the parents/legal guardians may be charged tuition and the student may be removed from school.

Warning and Affirmation: Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for purposes of enabling that student to attend on a tuition-free basis or to knowingly enroll or attempt to enroll as a student on a tuition-free basis when the student is known to be a non-resident of the School District. The District will seek prosecution to the full extent of the law any person who the District believes has committed any residency-related violation. Additionally, a civil lawsuit may be initiated by the District.

I affirm that I am a resident of this District and that the information presented in this affidavit and in connection with any investigation of my residency or the residency of the student is true, complete and accurate.

Signature of the person claiming custody /enrolling student **Date**

Comprobante de custodia y residencia

Como regla general, la ley de Illinois establece que la residencia de un estudiante se considera que es la misma que de la persona que tiene su custodia legal y sólo permite la inscripción y asistencia a clases en forma gratuita de los estudiantes que residan dentro del Distrito Escolar. La persona que diga tener la custodia también deberá residir en el Distrito. El presente formulario deberá ser llenado para ayudar al Distrito a determinar la residencia y custodia legal. El Distrito podrá investigar la residencia de cualquier estudiante antes o después de su inscripción y requerirles a las personas involucradas que brinden información adicional para que el Distrito pueda determinar la residencia. La inscripción no se habrá completado y la asistencia por lo general no será permitida hasta que todas las cuestiones referidas a la residencia queden resueltas.

I. Identificación (Favor de usar letra de molde):

Estudiante:

Nombre

Fecha de Nacimiento

Número de Identificación del Estudiante

Persona que manifiesta tener custodia/inscribiendo al estudiante:

Nombre

Dirección

Número Telefónico

Relación al estudiante

II. Residencia de la persona con quien vive el estudiante o que dice tener la custodia del estudiante:

Como comprobante inicial de la residencia, **la persona con quien vive el estudiante en el Distrito y que diga tener la custodia del estudiante** deberá adjuntar a este formulario por lo menos un documento de la Categoría A y por lo menos un documento de la Categoría B, los cuales deberán ser aceptables para el Distrito. Si la persona que inscribe al estudiante manifiesta que el estudiante (1) no tiene hogar o (2) asiste a la escuela del distrito anterior del estudiante por decisión del Departamento de Servicios para Niños y Familias, sólo marque la línea correspondiente de la Categoría C.

*** No se requiere que demuestre información personal (números de cuenta, cantidad de pagos, etc.) en estos documentos. Por favor siéntase libre de bloquear cualquier información personal que no se utilice como comprobante de su residencia. Todos los documentos deben ser recientes con la dirección donde reside el estudiante.**

*** Categoría A. Marque y adjunte una copia de al menos uno de los siguientes documentos:**

____ 1. La última factura de los impuestos propietarios para mi residencia con que me muestra como el contribuyente.
____ 2. Los documentos de una hipoteca.
____ 3. El contrato de renta firmado de mi residencia.
____ 4. La declaración del cierre de la compra de mi residencia.
____ 5. La Declaración Jurada del Residente Referente a la Residencia de Otros notariada (debe presentar 2 comprobantes de Categoría B)
____ 6. Una carta notariada que indica que mi arrendamiento es de mes a mes (debe presentar 2 comprobantes de Categoría B)

*** Categoría B. Marque y adjunte una copia de al menos uno de los siguientes documentos:**

____ 1. Factura del agua, electricidad o gas (fechado dentro de un mes de las fechas de inscripción del estudiante).
____ 2. Identificación con fotografía emitida por el gobierno con dirección actual en donde reside el estudiante/Carta de cambio de dirección de Illinois.
____ 3. Tarjeta de Asistencia Pública o de Estampillas de Comida, Carta de Asistencia Médica (con el nombre del padre/estudiante y dirección)
____ 4. Certificado de seguro vigente de propietario/inquilino.
____ 5. Factura reciente del Cable/Internet/ Dish
____ 6. Recibo de la calcomanía para vehículos de la ciudad.

Categoría C. Ninguno de los documentos de las categorías A o B precedentes corresponden porque:

____ 1. El estudiante no tiene hogar y reúne las condiciones para inscribirse bajo la Ley de Educación para Niños sin Hogar de Illinois.
____ 2. El estudiante se inscribe por decisión del Departamento de Servicios para Niños y Familias (DCFS), presente la constancia de la decisión del DCFS
____ 3. El Comprobante de Residencia será establecido en 30 días calendarios, sin embargo, SE DEBERÁ presentar un contrato de propiedad, declaración del cierre o renta como constancia de residencia inicial. Si el estudiante no se hace residente del distrito dentro de los 30 días, se les puede cobrar a los padres el costo de instrucción y puede ser excluido de la escuela.

Advertencia y declaración:

La ley de Illinois establece como delito, castigable con encarcelamiento y multas, la presentación intencional o voluntaria de información falsa sobre la residencia de un estudiante para permitirle asistir a clases en forma gratuita o deliberadamente inscribir o intentar inscribir a un estudiantes para que reciba educación gratuita cuando se sabe que el estudiante no es un residente del Distrito Escolar. El Distrito iniciará las acciones legales con toda la fuerza de la ley contra cualquier persona que el Distrito considere que ha cometido una violación relacionado con la residencia. Además, el Distrito podrá promover una causa civil.

Declaro ser residente de este Distrito y que la información presentada en esta declaración jurada y relacionada con cualquier investigación sobre mi residencia o la residencia del estudiante es cierta, completa y precisa.

Firma de la persona que reclama la custodia/matrícula al estudiante **Fecha**

PRE ADMISSION HEALTH INFORMATION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student's Name_____
Birthdate_____ Grade:_____

Has this child ever attended a U-46 school, including Preschool?

Yes_____ No_____ Where _____

Family History:

Number of children in family? _____
This child in order of birth? _____
Are all family members healthy?_____

Birth History:

Was mother healthy during pregnancy? _____
Was baby full term? _____ Any delivery problems? _____
Did mother and baby leave hospital on same day? _____

Developmental History:

Age of walking _____ Age of talking _____
Age toilet trained: day _____ night_____

Health History:

	Yes	No	
Does this child have:			
allergies	_____	_____	
asthma	_____	_____	When was last one?
recurrent ear infection	_____	_____	_____
any chronic illness	_____	_____	_____
any seizures	_____	_____	_____
any physical limitations	_____	_____	_____
any sleeping difficulties	_____	_____	_____
Has this child been:			
hospitalized	_____	_____	
seriously injured	_____	_____	
prescribed/on medication	_____	_____	
examined for vision	_____	_____	
Does he/she wear glasses	_____	_____	

Concerns:

Are there any health problems to which the teacher/nurse should be alerted?_____

Reminder:

I understand that all students must have a physical exam and complete record of immunizations on file at school in order to remain in attendance. (Illinois School Code, Sec. 27-8.1).

_____ _____
Parent Signature Date

PRE ADMISSION HEALTH INFORMATION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

Fecha:_____ Grado_____
Nombre del Estudiante_____Fecha de naciminento_____
Asistió este niño, alguna vez, a una escuela de U-46, incluyendo preescolar
Si_____ No_____ Dónde_____

Historial Familiar:

¿Número de niños en la familia?_____
¿En orden de nacimiento qué número es este niño?_____
¿Están todos los miembros de la familia sanos?_____

Historial de Nacimiento:

¿Estaba la madre sana durante el embarazo?_____
¿A los cuantos meses nació el bebé?_____
¿Algún problema durante el parto?_____
¿Salieron la madre y el niño del hospital el mismo día?_____

Historial de Desarrollo:

Edad en que comenzó a caminar _____
Edad en que comenzó a hablar _____
Edad en que comenzó a usar el baño: durante el día _____durante la noche____

Historial de Salud:

	Si	**No**	
Tiene este niño:			
alergias	_____	_____	
asma	_____	_____	¿Cuándo fue la última vez?
infecciones de oido frecuentemente	_____	_____	_____
alguna enfermedad crónica	_____	_____	_____
convulsiones	_____	_____	_____
alguna limitación fisica	_____	_____	_____
alguna dificultad para dormir	_____	_____	_____
Alguna vez ha sido o estado:			
hospitalizado	_____	_____	
gravemente herido	_____	_____	
en medicamentos recetados	_____	_____	
su visión examinada	_____	_____	
usa lentes	_____	_____	

Preocupaciones:

¿Existe algún problema de salud, el cual los maestros y la enfermera deben ser advertidos?_____

Recordatorio:

Entiendo que todos los estudiantes deben hacerse un examen físico y tener todas sus inmunizaciones en su arcnivo en la escuela para poder estar en asistencia. (Illinois School Code, Sec. 27-8.1).

_____
Firma del Padre/Madre

NOTARIZE
AFFIDAVITS

Affidavits are also renewed every school year.
Las Declaraciones Juradas también se renuevan cada ciclo escolar.

Affidavit of Resident Regrading Residency of Others

If you reside with another family, **you must fill out and notarized** the **Affidavit of Resident Regarding Residency of Others.**

Please also bring **TWO if you are providing an affidavit** of the following items:
*Utility Bill (Front page only, showing your name and address.)
*Valid government-issued picture ID with current address.
*Public Aid Card with current address at which the student resides
*Current homeowners/renters insurance certificate.
*Receipt for city vehicle sticker.

Declaración Jurada de Residente Respecto a Residencia de Otros

Si usted vive con un familiar o con otra persona, deberá completar y **notarizar la carta "Declaración Jurada de Residente Respecto a Residencia de Otros"**.

Favor de traer también **DOS de estos requisitos, si proporciona una Declaración Jurada**:
*factura de servicios públicos (la página de enfrente donde muestra su nombre y dirección)
*identificación válida con fotografía emitida por el gobierno con la dirección actual.
*Tarjeta de ayuda pública con la dirección actual en la que vive el estudiante.
*Certificado actual de seguro de vivienda/inquilino.
*Recibo de la calcomanía de la ciudad para el auto.

Affidavit of Resident Regarding Residency of Others

I, _____, being first duly sworn by a notary
(Owner/lessor of the Residence)

public, state that the following information is true:

1. I reside at: _____ _____ _____ _____
(House#) (Street) (City) (Zip)

My Phone Number is: _____

2. Also residing with me at this address are the following adults who seek to enroll their child(ren) in school as residents of School District U-46:

Adult Parent/Guardian Name(s)

_____

_____

3. The individual(s) named in No. 2 above have custody and control of the following children whom they seek to enroll in School District U-46:

Child(ren) Name(s)

_____

_____

_____

4. The individuals named above have been residing with me in my residence since:
_____

5. They are expected to continue residing with me until:
_____

6. The reasons they reside with me are:
_____

_____

_____

Warning and Affirmation

Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for purposes of enabling that student to attend on a tuition-free basis or to knowingly enroll or attempt

to enroll a student on a tuition-free basis when the student is known to be a non-resident of the District. The District will seek prosecution to the full extent of the law of any person who the District believes has committed any residency-related crime. Additionally, a civil lawsuit may be initiated by the District.

I affirm that I am a resident of this District and that the information presented to this Affidavit and in connection with any investigation of my residency or the residency of others who live with me is true, complete and accurate.

_____

***Signature of the School District Resident with Whom Other Adults and Students Live**

_____

Dated

*Subscribed and Sworn to before me on this _____ day

of _____, 20_____

_____

Notary Public

****Parent/Guardian Initials Required Below**

****_____ I further understand that this Affidavit expires at the end of the current school year and as parent/guardian I am required to provide updated proof of residency documents prior to completing my student's registration for the following school year.**

_____ _____

(Parent/Guardian Signature) (Parent/Guardian Print Name)

_____

(Date)

Declaración Jurada del Residente Referente a la Residencia de Otros

Yo, _____, declaro bajo juramento ante un notario público
(Dueño/arrendador de la residencia)

que la siguiente información es cierta y verdadera:

1. Mi domicilio es _____ (# de casa) _____ (Calle) _____ (Ciudad) _____ (Codigo postal)

   Mi numero de telefono es: _____

2. También viven conmigo, en esta residencia los siguientes adultos quienes buscan inscribir a su niño(s) en una escuela como residentes del Distrito Escolar U-46:

Nombre(s) de Padre/Tutor

_____

_____

3. Los individuos nombrados bajo el Num. 2 tienen la custodia y control de los siguientes niños quienes buscan inscribirse en el Distrito Escolar U-46:

Nombre(s) de hijo(s)

_____

_____

_____

4. Los individuos mencionados previamente han vivido conmigo en mi hogar desde:

   _____

5. Y se espera que vivan conmigo hasta:

   _____

6. La razón por qué ellos viven conmigo es:

   _____

   _____

Aviso y Declaración:
La ley de Illinois establece como delito, punible con encarcelamiento y multas, la presentación intencional o voluntaria de información falsa sobre la residencia de un estudiante para permitirle asistir a clases en forma gratuita o deliberadamente inscribir o intentar inscribir a un estudiantes para que reciba educación gratuita cuando se sabe que

el estudiante no es un residente del Distrito Escolar. El Distrito iniciará las acciones legales con toda la fuerza de la ley contra cualquier persona que el Distrito considere que ha cometido un delito relacionado con la residencia. Además, el Distrito podrá promover una causa civil.

Declaro ser residente de este Distrito y que la información presentada en esta declaración jurada y relacionada con cualquier investigación sobre mi residencia o la residencia de otras personas viviendo conmigo es cierta, completa y precisa.

_____

Firma del Residente del Distrito Escolar U-46 con quien otros adultos y estudiantes viven.

_____

Fecha

Subscribed and Sworn to before me on this _____ day

of _____, 20_____

_____

Notario Público

**** Los padres/tutor iniciales requeridas a continuación**

**_____ Entiendo que esta declaración jurada vence al final del año escolar actual y como padre o tutor estoy obligado a proporcionar la prueba actualizada de documentos de residencia antes de completar el registro de mi estudiante para el siguiente año escolar.

_____ _____

(Firma del padre/tutor) (Padre/tutor nombre en imprenta)

_____

(Fecha)

	DATE/FECHA	TIME/HORARIO	FORMAT/FORMATO LOCATION/UBICACIÓN
01	THURSDAY, JANUARY 9, 2025 JUEVES 9 DE ENERO DE 2025	6:30PM - 7:30PM	VIRTUAL ZOOM LINK HERE SCAN CODE FOR ZOOM LINK/ESCANEE EL CÓDIGO PARA OBTENER EL ENLACE DE ZOOM
02	WEDNESDAY, JANUARY 29, 2025 MIÉRCOLES 29 DE ENERO DE 2025	6:30PM - 7:30PM	VIRTUAL ZOOM LINK HERE SCAN CODE FOR ZOOM LINK/ESCANEE EL CÓDIGO PARA OBTENER EL ENLACE DE ZOOM
03	MONDAY, MARCH 10, 2025 LUNES 10 DE MARZO DE 2025	6:30PM - 7:30PM	IN PERSON/EN PERSONA GAIL BORDEN LIBRARY 270 N GROVE AVE, ELGIN
04	THURSDAY, APRIL 24, 2025 JUEVES 24 DE ABRIL DE 2025	6:30PM - 7:30PM	IN PERSON/EN PERSONA OTTER CREEK ELEMENTARY SCHOOL 2701 HOPPS RD., ELGIN, IL 60124

USE THIS QR CODE TO ACCESS THE MOST UP-TO-DATE SCHEDULE/
USE ESTE CÓDIGO PARA ACCEDER AL HORARIO MÁS ACTUALIZADO

USE THIS QR CODE TO ACCESS THE U-46 DUAL LANGUAGE SITE/
USE ESTE CÓDIGO PARA ACCEDER A LA PÁGINA WEB DL PROGRAMA DE LENGUAJE DUAL DE U-46

No Shots?
No Records?
NO SCHOOL!

PLEASE NOTE: If you are registering a child for Kindergarten & 6th Grade, you will need a physical and immunizations before the first day of school.

You do not need to have this done to register the child.

Beat the crowd, do it now!!!

TENGA EN CUENTA: Si está inscribiendo a un niño para el Jardín de Infancia y 6° Grado, necesitará un examen físico y vacunas antes del primer día de clases.

No es necesario tenerlo listo para poder registrar al niño.

Venza a la multitud y hágalo ahora!!!

U46 ACADEMIC SUCCESS FOR ALL

Health Requirements 2025-2026

Rev. 1-25

School Starts August 11, 2025, tentative requirements pending any IDPH updates for next year.

Students will be excluded from school if they do NOT have the following requirements on file by the first day of school. Schedules will be held for students in grades 7-12 until all health requirements are turned in.

Preschool/ Early Childhood	Physical Exam	Dated after 8/11/2024. Must include Diabetes screening/BMI, Health history & parent signature
	DPT	4 doses
	Polio (IPV)	3 doses
	Hib	1 dose after 15 months (or completed series by 12 months)
	MMR	1 dose (after 12 months)
	Varicella	1 dose (after 12 months)
	Hepatitis B	3 doses (third dose after 6 mos of age)
	Pneumococcal	Primary series, or proof of 1 dose after 24 months
	Lead screening/testing	Testing required for students residing in 60120 zip code

Kindergarten and students Entering Illinois school for 1st time	Physical Exam	Dated after 8/11/2024. Must include Diabetes screening/BMI, Health history & parent signature
	DPT	4 doses (last one after 4th birthday)
	Polio (IPV)	4 doses (last one after 4th birthday)
	MMR	2 doses (after 12 months)
	Varicella	2 doses (after 12 months)
	Lead screening/testing	Testing required for students residing in 60120 zip code
	Vision Exam	Completed by Optometrist, Ophthalmologist or physician who provides complete eye exams. Due by October 15.
	Dental Exam	Completed by licensed dentist. Due by May 15.

2nd Grade	Dental Exam	Completed by licensed dentist. Due by May 15.

6th Grade	Physical Exam	Dated after 8/11/2024. Must include Diabetes screening/BMI, Health history & parent signature
	Tdap	1 dose (must be on or after the 11th birthday)
	MMR	2 doses (after 12 months)
	Varicella	2 doses (after 12 months)
	Meningococcal	Proof of having received one dose on or after the 11th birthday.
	Hepatitis B	3 doses (third dose after 6 mos of age)
	Dental Exam	Completed by licensed dentist. Due by May 15.

9th Grade	Physical Exam	Dated after 8/11/2024. Must include Diabetes screening/BMI, Health history & parent signature
	Tdap	1 dose (must be after age 10)
	MMR	2 doses (after 12 months)
	Varicella	2 doses (after 12 months)
	Meningococcal	Proof of one dose after age 11
	Hepatitis B	3 doses (third dose after 6 mos of age)
	Dental Exam	**Completed by licensed dentist. Due by May 15**

12th Grade	Meningococcal	Minimum intervals for administration: The first dose received on or after the 11th birthday; second dose on or after the 16th birthday. An interval of at least eight weeks after the 1st dose. Only one dose is required if the first dose was received at 16 years of age or older.

State of Illinois

Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address, City, ZIP Code	Parent/Guardian, Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	**List:**	**MEDICATION** (Prescribed or taken on a regular basis)	☐ Yes ☐ No	**List:**

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems? ☐ Yes ☐ No

Bone/Joint problem/injury/scoliosis? ☐ Yes ☐ No

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** * Indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		**Endocrine**	☐	
Ears	☐	Screening Result:	**Gastrointestinal**	☐	
Eyes	☐	Screening Result:	**Genito-Urinary**	☐	LMP:
Nose	☐		**Neurological**	☐	
Throat	☐		**Musculoskeletal**	☐	
Mouth/Dental	☐		**Spinal Exam**	☐	
Cardiovascular/HTN	☐		**Nutritional Status**	☐	
Respiratory	☐	☐ Diagnosis of Asthma	**Mental Health**	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			**Other**	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address | City | ZIP Code | Parent/Guardian | Telephone (home/work)

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro)	☐ Sí ☐ No	**Anote todas las alergias:**	**MEDICAMENTOS** (Recetados o tomados con regularidad)	☐ Sí ☐ No	**Anote todos los medicamentos:**

¿Tiene diagnóstico de asthma?	☐ Sí ☐ No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	☐ Sí ☐ No	
¿Despierta el niño tosiendo en la noche?	☐ Sí ☐ No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene defectos de nacimiento?	☐ Sí ☐ No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene retrasos del desarrollo?	☐ Sí ☐ No		¿Ha tenido heridas graves o enfermedades?	☐ Sí ☐ No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	☐ Sí ☐ No		¿Prueba positiva de TB (Pasado o Presente)?	☐ Sí* ☐ No	*Sí contestó sí, refiera al departamento de salud local
¿Tiene diabetes?	☐ Sí ☐ No		¿Enfermedad de TB (Pasado o Presente)?	☐ Sí* ☐ No	
¿Tiene heridas en la cabeza/golpe/desmayo?	☐ Sí ☐ No		¿Usa tabaco (tipo, frecuencia)?	☐ Sí ☐ No	
¿Tiene convulsiones? Cómo se manifiestan?	☐ Sí ☐ No		¿Toma alcohol/drogas?	☐ Sí ☐ No	
¿Tiene problemas cardiacos/Dificultad para respirar?	☐ Sí ☐ No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	☐ Sí ☐ No	
¿Tiene soplo en el corazón/presión arterial alta?	☐ Sí ☐ No		☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro		
¿Tiene mareos o dolor de pecho al hacer ejercicios?	☐ Sí ☐ No				
¿Problemas con los ojos/visión? _____ ☐ Lentes ☐ Lentes de Contacto Último examen _____			**Información Adicional:**		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los oídos/no oye bien?	☐ Sí ☐ No		**Firma del Padre/ Tutor:** _____ **Fecha:** _____		
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	☐ Sí ☐ No				

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** * Indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

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ALTERNATIVE PROOF OF IMMUNITY

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*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		**Endocrine**	☐	
Ears	☐	Screening Result:	**Gastrointestinal**	☐	
Eyes	☐	Screening Result:	**Genito-Urinary**	☐	LMP:
Nose	☐		**Neurological**	☐	
Throat	☐		**Musculoskeletal**	☐	
Mouth/Dental	☐		**Spinal Exam**	☐	
Cardiovascular/HTN	☐		**Nutritional Status**	☐	
Respiratory	☐	☐ Diagnosis of Asthma	**Mental Health**	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			**Other**	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

To Be Completed By Examining Doctor

Case History Date of Exam: _____

Ocular History: ❑ Normal or Positive for: _____
Medical History: ❑ Normal or Positive for: _____
Drug Allergies: ❑ NKDA or Allergic to: _____
Other Information: _____

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	
Neurological Integrity (pupils)	❑	❑	❑	
Binocular Function (stereopsis)	❑	❑	❑	
Accommodation and Vergence	❑	❑	❑	
Color Vision	❑	❑	❑	
IOP (glaucoma)	❑	❑	❑	
Oculomotor Assessment	❑	❑	❑	
Other: _____	❑	❑	❑	

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: _____

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses should be worn for: ❑ Constant Wear ❑ Near Vision ❑ Far Vision ❑ May Be Removed for Physical Education
2. Preferential seating recommended: ❑ No ❑ Yes Comments: _____
3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months ❑ Other _____
4. _____
5. _____

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

_____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

Phone: _____

Consent of Parent or Guardian
I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

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Estado de Illinois
Departamento de Salud Publica

FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

La ley de Illinois (Child Health Examination Code, 77 III. Código Administrativo 665) índice que todos los niños en kínder, segundo, sexto, y noveno grados en escuela pública, privado, o parroquial adquieran examinación dental. La examinación se tiene que haber hecho entre 18 meses antes de 15 Mayo del año escolar. Un dentista licenciado tiene que hacer el examen, firmar y ponerle fecha a esta Formulario Comprobante de Examen Dental Escolar. Si no puede obtener este examen requerido, completa el Formulario de Renuncia Voluntaria del Examen Dental Escolar

Este examen importante le dejara saber si hay algún problema que requiere atención de un dentista. Los Niños necesitan buena salud bucal para habla con confianza, expresar se, ser saludables y ser listos para aprender. La salud bucal malo ha sido relacionado con bajo actuación escolar, malas relaciones sociales, y menos éxito más adelante in la vida. Por esta razón, le damos gracia por su contribución al salud y bien estar de su niño.

Para ser completado por el padre/madre (por favor impresión):

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: (Mes/Dia/Año)
Dirección:	Calle	Ciudad		Código Postal
Nombre de la Escuela:		Código Postal	Grado:	Sexo: □ Masculino □ Femenino
Nombre del padre/madre o encargado				
Raza/Etnicidad del Estudiante: □ Blanco □ Nativo de Alaska o Indio Americano □ Nativo de Hawái o otras islas del Pacífico □ Hispano/Latino □ Afroamericano □ Asiático □ Multirracial □ Otro_____ □ Desconocido				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____